Arizona Department of Health Services

Office for Children with Special Health Care Needs

DOCTOR REFERRAL/AUTHORIZATION

Dear Doctor: _____ Date: _____

Member's name: _____ Date of Birth: _____

Has applied for/or is receiving services through the Arizona Department of Health Services, Office for Children with Special Health Care Needs, Family Resource Coordination Program.

( ) Children with Traumatic Brain Injury (TBI)
( ) Children with Spinal Cord Injury (SCI)
( ) Children and Youth with Special Health Care Needs (CYSHCN)

We have…
( ) Completed an Individual Service Plan (ISP)
( ) Assisted the member/family in identifying their needs/resources/priorities/concerns and desired outcome(s).
( ) Other_____

We will …
( ) Assist the family in coordination of services
( ) Identify additional community and/or family resources
( ) Other_____

Members/Parents have…
( ) Signed Authorization for Release of Information (see attached)

Members/Parents will…
( ) Look within their family, friends, and community for additional supports and services

Could you help with…
( ) Providing information requested on Authorization for Release of Information
( ) Other_____

Referral/Authorization for:

( ) developmental evaluation	( ) hearing evaluation	( ) neuropsychological evaluation
( ) physical therapy	( ) vision evaluation	( ) psychological evaluation
( ) occupational therapy	( ) cognitive evaluation	( ) other _____
( ) speech language therapy	( ) nutrition	( ) _____
( ) rehabilitation	( ) vision services	( ) _____

THANK YOU